Maryland Million Hearts Quality Improvement Project Health Care Track 2

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  - ✓ NCQA – Recognition
  - ✓ Discern Consulting LLC – Payment Development
  - ✓ Social and Scientific Systems – Data Aggregation and Attribution

PATIENT CENTERED MEDICAL HOME

CRISP

illion Hearts™

JOHNS HOPKINS MEDICINE

NCQA Measuring quality. Improving health care.

MHCC MARYLAND HEALTH CARE COMMISSION

MARYLAND

MCHRC Maryland Community Health Resources Commission

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Status of the ABCS

Aspirin	People at increased risk of cardiovascular events who are taking aspirin	47%
Blood pressure	People with hypertension who have adequately controlled blood pressure	46%
Cholesterol	People with high cholesterol who are effectively managed	33%
Smoking	People trying to quit smoking who get help	23%

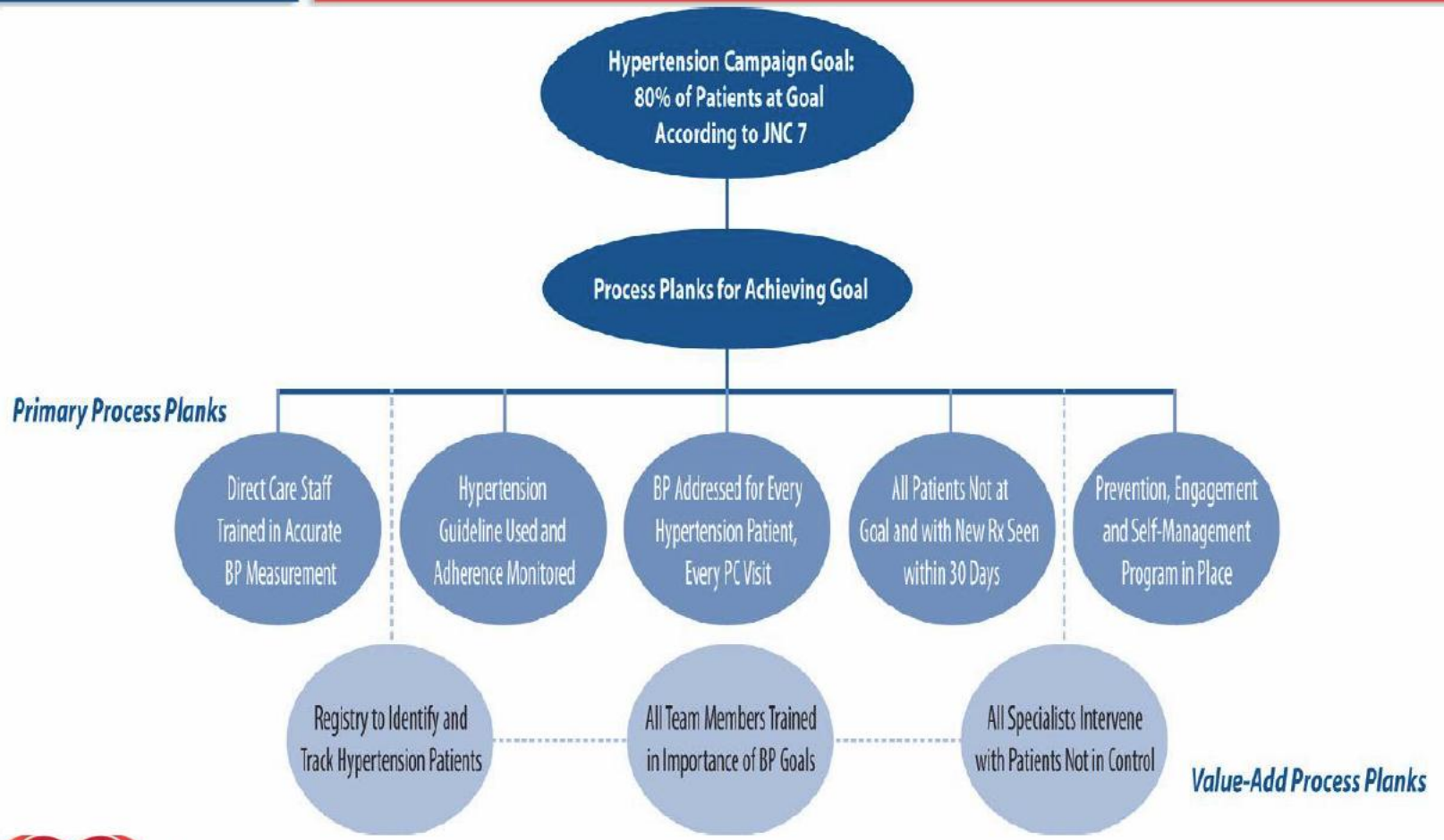
CDC. MMWR. 2011;60(36);1248–51.

Using data to inform clinical quality improvement

- NQF 18

- The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation JNC-7: Treating SBP and DBP to targets that are <140/90 mmHg is associated with a decrease in CVD complications.

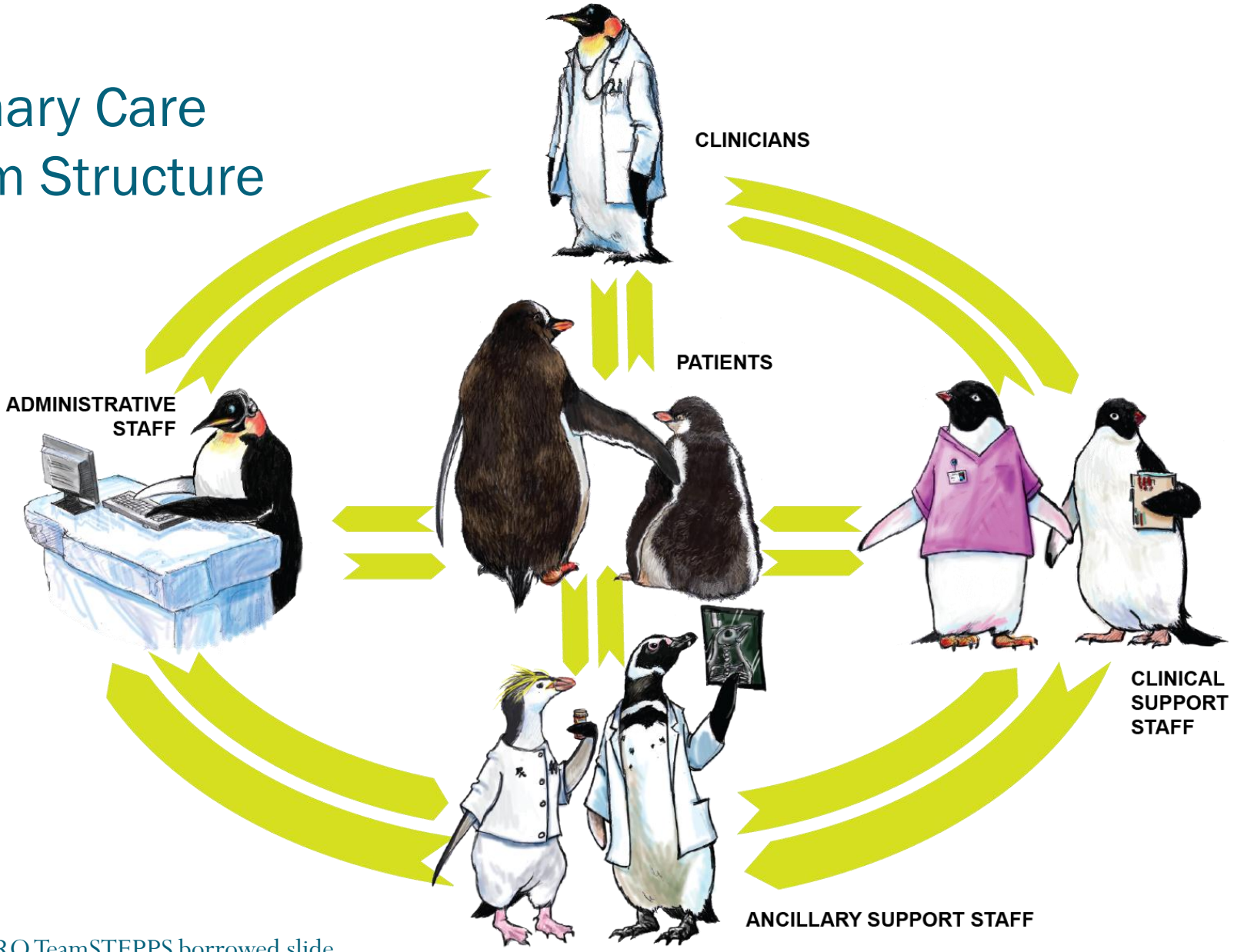
Campaign Planks



Measure Up Pressure Down™
American Medical Group Foundation

AMGA
American Medical Group Association®

Primary Care Team Structure



AHRQ TeamSTEPPS borrowed slide

Operationalizing Quality Improvement

- **Direct care staff training on accurate BP measurement**
- **Hypertension guideline used and adherence monitored**
- **BP addressed for every patient, every primary care visit**
- **Tobacco use addressed with every patient**
- **All patients not at goal and with new Rx seen within 30 days**
- **Prevention, engagement & self-management program in place.**

PATIENT SELF-MANAGEMENT AND PATIENT EDUCATION

- ***Self-Management***
  - Provide individualized patient education and assist the patient with Self-Management of their disease. Document the overall content of education, (e.g., side-effects of meds and when to report), and the patient's response to teaching.
  - Encourage use of the patient portal where available.
- ***Red Flags***
  - Provide patient and family education on "red flags" that could indicate a complication or exacerbation, requiring a call to the doctor, CM, or other in-home service provider to prevent potential ED visit/readmission.
  - Utilize Motivational Interviewing techniques, "teach-back", and other evidence-based patient education strategies for optimal outcomes.

Primary Care Office Environment

NQF 28

- At intake Medical Assistant queries whether patient uses tobacco and documents in EHR
- MA informs the practitioner that the patient uses tobacco
- Practitioner reviews record, queries patient
- Counseling and documentation in EHR
- Self Management
- MDQuit line and Fax to Assist Program
  - http://mdquit.org/
  - http://mdquit.org/fax-to-assist

Tobacco Counseling

The 5 "A"s

- ASSESS behavioral health risk(s) and factors affecting behavior change
- ADVISE behavior change through clear, specific, and personalized directions, including personal health harms and benefits information
- AGREE upon appropriate treatment goals and methods
- ASSIST the patient using behavior change techniques in achieving goals by acquiring the skills, confidence, and social/environmental supports for change
- ARRANGE follow-up contacts (in-person or by phone) to provide ongoing assistance/support and to adjust plan

Questions

Comments?